Policy and Program Changes

State fiscal year 2003 brought a number of policy and program changes that were implemented either as a result of legislative or federal mandates or at the discretion of the Division of Medical Assistance (DMA).

Policy Changes Enacted by Mandates

Asset Policy Change

DMA adopted the Supplemental Security Income (SSI) method for considering equity value in incomeproducing property for aged, blind, and disabled persons. Accordingly, Medicaid no longer excludes the entire equity value of income-producing property for eligibles in the Medically Needy category. Any equity over $6,000 is a countable resource. This change does not affect business property such as an active farm. This policy change applies only to recipients enrolled in Medicaid as of December 1, 2002. Additionally, the General Assembly authorized sanctioning transfers of tenancy-in-common interest in real property. The uncompensated transfer of tenancy-in-common interest in real property results in a sanction unless it is transferred to an
allowable person.

Transfer of Assets Policy for Specified Home Care Services

Effective with dates of service of February 1, 2003 and after, DMA began to apply the federal transfer of asset policies to Medicaid recipients in the aged, blind, disabled and qualified Medicare beneficiaries (MQBQ) eligibility categories receiving the following services: personal care in private residences, home health services (including the supplies provided by home health agencies), durable medical equipment (including the supplies provided by durable medical equipment providers), home infusion therapy, supplies on the home health fee schedule provided by private duty nursing providers to their patients (not including nursing care). This policy change was similar to the transfer of asset requirements currently in place for Medicaid eligibles receiving care at nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR), as well as for those recipients participating in the Community Alternatives Programs. The policy change did not apply to adult care residents receiving State/County Special Assistance, but it does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories.

Drug Utilization Management

Various drug utilization measures were implemented to expand prescription drug cost containment, including expanding the use of generic drugs and a preferred drug list. One such initiative was the pilot ACCESS II and III Prescription Advantage List (PAL). The ACCESS Program's clinical directors developed a voluntary PAL as an educational resource for physicians in the ACCESS II and III programs and, beginning November 1, 2002, a list

of FDA approved drugs was piloted in ACCESS sites. The list placed drugs in the 10 highest cost classes into tiers based solely on their Average Wholesale Price (AWP). This pilot effort was intended to assess physician acceptance of a voluntary list. There was no prior approval process associated with the choice of drugs on the list. Medicaid continued to pay for any medication a physician considered medically necessary for the patient regardless of cost.

Another ACCESS II and III drug utilization initiative, the Nursing Home Polypharmacy Project, was piloted in November 2002. Benefits of the initiative include the potential for use of more appropriate drugs for the elderly and an increase in coordination between pharmacists and physicians. The initiative will be evaluated based on the following aims: decreased prescription drug costs; the preservation or the enhanced quality of prescription-drug related care; and a decrease in other health care service costs.

The Nursing Home Polypharmacy Project represents an effort by the ACCESS Medical Directors team to better manage prescribing practices for a patient population that averages nine prescriptions per month each. The program depends on the interaction and collaboration between the consultant pharmacist and the prescribing physician. Only the physician can authorize the recommended change to a recipient's drug regimen.

The medications in this initiative will be flagged if: 1) they appear on the PAL; 2) they represent a therapeutic duplication; 3) they appear on the Beers list; 4) the length of therapy appears excessive; or 5) the drugs appear on a list developed by a committee of long-term care pharmacists that feature drugs associated with potential significant savings.

Personal Care Services Limitations

The monthly limit for Personal Care Services was reduced from 80 hours per month to 60 hours per month effective with date of service December 1, 2002.

Pregnant Women Coverage for Minors

The N.C. Legislature mandated a policy change, to be effective October 1, 2002, that would have modified the determination of eligibility for pregnant women coverage for minors by the counting of parental income if the minor is residing in the parents' home as long as the minor has not been married, has not served in the military or has not been legally emancipated. The Centers for Medicare and Medicaid Services denied the State Plan amendment submitted by DMA that would have authorized this change, thus the policy was not changed.

Hospital Payments

NC Medicaid payments to hospitals were reduced by 0.5 percent. This was implemented through system and process changes.

Prospective Rates for Home Health Services

A prospective rate payment system was established for home health services. The new system pays for services based on an assessment of the specific needs of the Medicaid recipient. Payment for services is no longer tied to the number of provider visits.

Optional Services

Coverage of routine circumcision procedures were eliminated effective with date of service December 1, 2002.

ACCESS II and III Expansion and Cost Savings

The Medicaid budget was reduced to reflect anticipated savings from the expansion of ACCESS II and III care management activities including reducing hospital admissions, reducing emergency department visits, using best prescribing practices, increasing generic prescribing, implementing polypharmacy review, reducing therapy visits and better management of high risk/high cost patients. The entire NC Medicaid Managed Care Program, consisting of Carolina ACCESS, ACCESS II and III, and HMO's has been renamed "Community Care of North Carolina". Enrollment in ACCESS II and III is anticipated to increase gradually from the current level of 250,000 to 650,000. To encourage the expansion of ACCESS II and III networks, effective April 1, 2003, the monthly case management fee for Carolina ACCESS providers not linked with an ACCESS II and III administrative entity was reduced to $1.00 per member per month, while those linked with ACCESS II and III, and working on care management activities, continued to receive $2.50 per member per month.

Medicare Issues

Effective with dates of service October 1, 2002, Medicaid medical coverage policy was applied to Medicare crossover claims. Crossover claims are those claims that Medicare submits to DMA for health-care services provided to Medicare-Medicaid dual eligible recipients where Medicare is considered to be the primary payer. By March 1, 2005, Medicaid payment of a dual-eligible's Medicare Part B deductible and co-payments will be limited to the amount that would be paid for the rendered Medicaid service using Medicaid rates.

Case Management Services

Case management services for adults and children were reduced by lowering reimbursement rates, streamlining services and eliminating duplicative services.

Reimbursement Rate Reductions

Reimbursement rates for high-risk intervention, optical services and services provided by ambulatory surgical centers were reduced by 5 percent. Reimbursement rates for durable medical equipment and supplies, home health supplies and home infusion therapy were also reduced.

Medicare Coverage in Nursing Facilities

Effective with dates of service December 1, 2002, DMA began requiring nursing facilities to bill NC Medicaid for services only after the appropriate services had been billed to Medicare.

HIPAA Compliance

NC Medicaid implemented Health Insurance Portability and Accountability Act (HIPAA) standard transactions on May 1, 2003. Providers were required to submit electronic claims in the pre-HIPAA format until May 1, 2003. After May 1, 2003, Medicaid began accepting electronic claims in the new HIPAA format and will require the new format after October 16, 2003.

Policy Changes Not Mandated

Change in Carolina ACCESS Override Policy

Effective September 1, 2002, Carolina ACCESS overrides were no longer approved when an enrollee has failed to establish a medical record with the primary care provider designated on the enrollee's Medicaid identification card.

Outpatient Specialized Therapy Services

Beginning October 1, 2002, Medical Review of North Carolina began processing the requests for prior approval of outpatient specialized therapy services provided to all Medicaid recipients. Therapy services encompass all outpatient treatment for physical, occupational, speech, respiratory and audiological therapy regardless of where the services are provided. Additionally, specific medical necessity criteria were incorporated into the Outpatient Specialized Therapies medical coverage policy.

"Medically Necessary" Replaces "Dispense as Written"

Effective January 1, 2003, the words "medically necessary" written on a prescription were required to dispense a trade or brand name drug, except for antipsychotic drugs and drugs listed in the narrow therapeutic index.

Mental Health Services for HMO Enrollees Provided by Direct-Enrolled Mental Health Providers

Beginning with dates of service on or after February 1, 2003, direct-enrolled mental health providers were allowed to bill Medicaid for services rendered to HMO-enrolled recipients without a referral from the Area Mental Health Authority.

Note: For a brief history of the NC Medicaid Program and a year-by-year record of program and policy changes over the years, please go to the following website:
http://www.dhhs.state.nc.us/dma/publications.htm